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To: Home Health Agencies

From: Judy Fryback, Director
Bureau of Quality Assurance

Guidelines for Therapy Orders

The Bureau of Quality Assurance has been aware of questions related to the interpretation of the federal regulation related to therapy services, found at 42 CFR 484.18(a). The regulation reads as follows: **Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration.**

In response, the Bureau formed a workgroup in July 1997 comprised of home health agency therapists, home health surveyors, and other BQA staff. The workgroup met to discuss discrepancies in interpretations and reach a mutual agreement on the guidelines for therapy orders.

The objectives of the group were:

- To establish guidelines for the surveyors, therapists, and home health agencies to follow concerning provisions of therapy services that conform to both regulatory compliance and the therapist scope of practice.
- To provide for a consistent development of the therapy plan of care, resulting in positive patient outcomes.
- To ensure a clear understanding of the patient goals, and interventions necessary to achieve them.

GUIDELINES

To meet the intent of 42 CFR 484.18(a) the following elements **MUST** be included in the therapy plan of care: *the patient's functional limitations/problems, measurable time-specific goals, the frequency and duration of the services (goal specific, intervention specific or global), and the interventions (procedures and modalities).* The therapy plan of care needs to provide a clear picture of the patient's diagnosis, functional problems (needs), goals to meet the needs, the time it will take to meet the goals, and the therapist interventions (plan).

42 CFR 484.18(a) also requires that, following the completion of the evaluation visit, the physician is consulted to obtain approval of the therapy plan to be implemented. In addition, the physician must be consulted to obtain approval of additions or modifications to the therapy frequency, duration and/or interventions.

When a therapist identifies the utilization of a home exercise program, copies must be included in both the clinical record and in the home. Maintaining a copy of the therapy plan in the clinical record meets the intent of 42 CFR 484.48 (clinical records) that requires the clinical record to contain pertinent past and current findings in accordance with accepted professional standards for every patient receiving home health services.

The following examples are provided as guides for the development of home health occupational and physical therapy and speech/language pathology plans of care.

Occupational Therapy Examples:

Patient # 1: Diagnosis (Dx): Right (R) hip fracture with open reduction internal fixation(ORIF), R shoulder bruise, deep vein thrombosis (DVT) 04/23/97.

Functional problems (include date assessed):

Requires standby-minimal assist for tub transfer. Requires assist for shower.

Goals (include date established):

Independent tub transfer by 05/16/97.
Independent with shower by 05/16/97.
Patient will verbalize and demonstrate safety knowledge and precautions relative to tub transfer and shower by 05/16/97.

Interventions (plan of care):

Therapy 3 times per week for 6 weeks, Activities of daily living (ADL) training, safety training.

Patient # 2: Dx: Left Cerebral vascular accident (CVA) with hemiparesis, Degenerative joint disease (DJD) hands.

Problems (include date identified):

1. Patient at risk for right upper extremity (RUE) contractures and pain due to decreased motor ability.
2. Patient unable to access/use phone to contact family.
3. Dependent for wheelchair mobility.
4. Needs assist with bathing, dressing, and toileting, although she is satisfied with Community Based Residential Facility (CBRF) staff assist.

Goals (include date established):

1. Patient will be independent with home program for right upper extremity (RUE) passive range of motion (PROM) to prevent contractures and pain by 6/15/97.
2. Patient able to propel wheelchair to/from kitchen to retrieve food/beverage by 6/15/97.
3. Patient able to contact family via phone by 6/15/97.

Interventions (plan of care):

Therapy 1 time per week for 9 weeks. Safety assessment, therapeutic activity for right upper extremity (RUE), patient education, adaptive equipment (RUE arm tray), graded activities of daily living (ADL) training.

Physical Therapy Examples:

Patient # 3: Dx: Fracture pelvis, right colles fracture, osteoporosis

Problems (include date identified):

1. Difficulty walking. Unable to negotiate uneven surfaces, ambulates with wheeled walker for 50 feet.
2. History of falls.
3. Gait deficits that limit safety and endurance in ambulation.
4. Decreased lower extremity (LE) strength (hip abductor 2+/5).

Goals (include date established):

1. Patient will be independent with wheeled walker for 300 ft. on level surfaces and driveway by 10/7/97.
2. Patient will manage the outside door independently by 10/7/97.
3. Patient will be free from falls for 4 weeks.
4. Increase hip abduction strength to 3+/5 bilaterally for good stability in gait by 11/7/97.
5. Patient will ambulate with equal step length and show push-off by 11/7/97.
6. Patient will be independent with quad cane for ambulation on all surfaces by 11/7/97.
7. Patient will require standby assist or less for negotiation of stairs to second level of home by 11/14/97.

Interventions (plan of care):

Therapy will be provided 2 times per week for the next 5 weeks.
Therapeutic exercises to lower extremities and gait training.

Patient # 4: Dx: Severe degenerative joint disease (DJD) both knees, Congestive heart failure (CHF), Congestive obstructive pulmonary disease (COPD), neurogenic bladder.

Functional problems (include date assessed):

1. Decreased mobility. Patient walks only 40 feet with cane due to bilateral knee pain.
2. Slow and difficult transfers.
3. Decreased lower extremity (LE) strength: 3+/5 in LE's.
4. Fair balance. Patient needs 2 handed support for all balance tests.

Goals (include date established):

1. Independent ambulation with cane for up to 100 ft. so patient can exit the home in 2 weeks.
2. Independent and safe transfers on/off bed, chair, toilet, bath bench in 3 weeks.
3. Increase LE strength to 4/5 for easier, safer transfers and ambulation in 3 weeks.
4. Independent compliance with home program for LE strengthening and range of motion (ROM) in 3 weeks.

Interventions (plan of care):

Gait training (cane), transfer training, therapeutic exercise (including LE strengthening and balance), home program instruction. Therapy services 2 times per week for 3 weeks.

Speech/Language Pathology Examples:

Patient #5: Dx: Left Cerebral vascular accident (CVA), aphasia

Problems (include date identified):

1. Mild impairment in comprehension of multi-step directions and conversation.
2. Unable to communicate basic needs to family due to word retrieval problems with paraphasic errors.
3. Mild impairment in reading comprehension. Unable to read materials at the paragraph level.

Goals (include date established):

1. Patient will comprehend multi-step verbal directions in functional setting with 85% accuracy by 2/28/97.
2. Patient will utilize compensatory techniques to facilitate word recall with 85% accuracy by 2/1/97.
3. Patient will comprehend functional written information with 85% accuracy by 2/28/97.
4. Patient will name objects on confrontation with 90% accuracy to communicate basic needs by 2/14/97.

Interventions (plan of care):

Language disorder treatment (examples include cards with objects) 2 times per week for 9 weeks.

Patient # 6: Dx: Acute left Cerebral vascular accident (CVA), history cerebellar CVA 1996.

Functional problems (include date assessed):

1. Severe difficulty following simple level directions and conversation from family and caregivers; decreasing safety and follow through.
2. Cannot verbally express wants and needs due to word recall deficits and inability to put words into simple thoughts.
3. Patient's verbal yes/no response is not consistent.
4. Patient is inconsistent with single word reading comprehension.
5. Cannot copy single letters or numbers.

Goals (include date established):

1. Patient will learn exercises and compensatory strategies to comprehend 1 - 2 step directions and yes/no questions for functional communication with 80% accuracy.
2. Increase gestural, speech motor, speech sound, and single word imitations through compensatory strategies to 60%.
3. Patient will learn picture board communication up to 10 pictures with 70% accuracy for communication of basic needs.
4. Patient will learn picture - word matching skills to 70% accuracy for functional communication.
5. Patient will copy single letters or numbers with 60% accuracy.

Plan of care (interventions):

Speech/language disorder treatment once per week for 6 weeks. Provide patient and caregiver with instruction of home program to be carried out in the absence of the speech/language pathologist.

Questions related to this information can be directed to Barbara Woodford, Nurse Consultant, Provider Regulation & Quality Improvement Section at (608) 264-9896 or Stephen Schlough, Chief, Health Services Section at (608) 266-3878.

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